1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15692 15687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MD — b. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING — c. LENGTH OF STAY IN 1b: —	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COLLEGE PARK
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL	d. STREET ADDRESS: 9736 5PT. AVE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print)	First: BERTHA	Middle: C.	Last: NAYLOR	4. DATE OF DEATH	Month: 11	Day: 14	Year: 1967	
5. SEX: F	6. COLOR OR RACE: CAUCASIAN	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 8-21-18	9. AGE (In years last birthday): 49 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Typist	10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.	11. BIRTHPLACE (County & State, or foreign country): Massachusetts	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME: ABE CURELOP	14. MOTHER'S MAIDEN NAME: Jennie - - - -							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): - - -	16. SOCIAL SECURITY NO.: - - - -	17. INFORMANT: FRANKLIN J. NAYLOR, SEE ITEM #2	Address				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Carcinoma of prostate with generalized metastases — (months)
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1750

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 19[illegible], to Nov 14, 19[illegible], that (I) (we) last saw the deceased alive on Nov 14 19[illegible], and that death occurred at 7:25 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Nov 14, 1967

22c. PHYSICIAN'S NAME (Type): BLAINE H. ETG — 22d. ADDRESS: 6411 Glenallen Rd Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE THEREOF: 11-16-1967	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Suitland, Md.		
24. FUNERAL DIRECTOR: Jos. Gawler's Sons Inc.	ADDRESS: Wash. DC	25a. REC'D BY REGISTRAR DATE: NOV 20 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15693

CERTIFICATE OF DEATH

15688

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4410 Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edmund — Middle M. — Last Neary
4. DATE OF DEATH: Month Nov. — Day 21 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 6 1908
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Neary
14. MOTHER'S MAIDEN NAME: Hazel Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 135-09-5601
17. INFORMANT: Mrs Ruth Neary — Address: Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture aneurism, saccular — INTERVAL BETWEEN ONSET AND DEATH: Min.
DUE TO (b): abdominal aorta
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451X
DUE TO (c): Arteriosclerosis — Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to 21 Nov, 1967, that (I) (we) last saw the deceased alive on 21 Nov 1967, and that death occurred at 6 pm M, from causes and on the date stated above.

22a. SIGNATURE: Horace Bernton — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/22/67
22c. PHYSICIAN'S NAME (Type): Horace Bernton, M.D.
22d. ADDRESS: 4743 Bradley Blvd. Chevy Chase, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/25/67
23c. NAME OF CEMETERY OR CREMATORY: Hollywood Cem.
23d. LOCATION (City or Town) (County) (State): Union, New Jersey

24. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: NOV 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15694 15689

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. & HOSP

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C. — b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 3009 13th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN — Middle D — Last NORVILLE
4. DATE OF DEATH: Month NOVEMBER — Day 8 — Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 30, 1898
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SCHOOL TEACHER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander Dawley
14. MOTHER'S MAIDEN NAME: Amanda Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 579-56-7012
17. INFORMANT: Address: MRS. EVA SMITH - DAUGHTER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Ventricular Fibrillation
DUE TO (c): Arteriosclerotic Heart Disease
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. REAP M.D. Address (Street, city (town), or county): Wheaton
22. DATE SIGNED: Nov. 9, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/15/67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem. Park
23d. LOCATION (City or Town) (County) (State): Landover PG MD.

24. FUNERAL DIRECTOR: William W. Woodford
ADDRESS: 1622 11th St., N.W., D.C. N.W.D.C. 20001
25a. REC'D BY REGISTRAR DATE: NOV 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15693 — 15690

CERTIFICATE OF DEATH (Margaret J. O'Bree)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

cleared c MEDICAL EXAMINER/L.S.

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK c. LENGTH OF STAY IN 1b: D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. & HOSP.	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: PR. GEO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK d. STREET ADDRESS: 401 BOYD AVE. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): ~~O'BREE~~ — First: ANNA — Middle: MARGARET — Last: O'BREE	4. DATE OF DEATH: Month: NOVEMBER — Day: 5 — Year: 1967
5. SEX: FEMALE	6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: MARCH 2, 1911
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED, Dietary Dept.	10b. KIND OF BUSINESS OR INDUSTRY: FEDERAL GOVT.
11. BIRTHPLACE (County & State, or foreign country): TEXAS	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: ORGIN JULIEN	14. MOTHER'S MAIDEN NAME: MARY HOLCOMB
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO	16. SOCIAL SECURITY NO.
17. INFORMANT: HOSP. RECORDS. — Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1538
IMMEDIATE CAUSE (a): CARCINOMATOSIS
DUE TO
(b): ADENOCARCINOMA OF COLON
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) ~~(this hospital)~~ attended the deceased from 2-28-67, 19__ to NOVEMBER 1967, that (I) ~~(we)~~ last saw the deceased alive on Nov. 3 1967, and that death occurred at 5:10 PM, from causes and on the date stated above.

22a. SIGNATURE: Morrill C. Quinnam Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11-5-67

22c. PHYSICIAN'S NAME (Type): MORRILL C. QUINNAM JR. — 22d. ADDRESS: 831 UNIV. BLVD. E., SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: NOV. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY: City Cemetery	23d. LOCATION (City or Town): Whitewright	(County): (State): Texas
24. FUNERAL DIRECTOR: Arthur Walters	ADDRESS: 257 Cottage St. N.W. Washington, D.C. 20012	25a. REC'D BY REGISTRAR DATE: NOV 8 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

2 - 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15698 — 15691

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 58 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS: 120 Oakland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

25-3

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Ray — Last: Oldaker

4. DATE OF DEATH: Month: November — Day: 3 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 August 1948

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Oldaker

14. MOTHER'S MAIDEN NAME: Georgia Shelhammer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 233-70-5969

17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 14 Hours

2043

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Gram Negative Septicemia — 36 Hours

DUE TO

(c) Acute Myelogenous Leukemia — 12 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from September 6, 19 67, to November 3 1967, that (I) (we) last saw the deceased alive on November 3 19 67, and that death occurred at 7:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: Thomas Clancy M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Thomas P. Clancy, M. D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-6-67

23c. NAME OF CEMETERY OR CREMATORY: Stonewall Park Cem.

23d. LOCATION (City or Town) (County) (State): Nutter Fort, W. Va.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland

25a. RECD BY REGISTRAR DATE: NOV 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

Item 18-21 Film #395
11-30-67 mt
15697

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15392

TO PHYSICIAN-MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 3333 UNIVERSITY BLVD. W. #108
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LUCY Middle ANN Last OLMERT

4. DATE OF DEATH: Month NOVEMBER Day 14 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 7, 1921

9. AGE (In years last birthday): 45 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Eppa L. Norris

14. MOTHER'S MAIDEN NAME: Sue Ginnavan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 579-22-8613

17. INFORMANT: William Norris — Address: 9505 Midwood Road Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory Failure due
DUE TO (b): to Barbiturate Intoxication ,
DUE TO (c): Apparently Self-administered

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1102

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Deceased took overdose of Nembutal

20c. TIME OF INJURY Month, Day, Year: ? Hour a.m. p.m. 11-14 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Kensington (County) Mont (State) Md

21. I certify that I took charge of the remains described above, ☒ and ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. CAL. EXAMINER ☐
DEPUTY MED. CAL. EXAMINER ☒

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D. Address: Wheaton

22. DATE SIGNED: Nov. 14, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 17, 1967

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION (City or Town) Silver Spring (County) Maryland (State)

24. FUNERAL DIRECTOR: John D. Thomas, Jake B. Thomas — ADDRESS: 8434 Georgia Ave. — Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: NOV 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15ME (5)
6M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15698 — 15693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 7008 KENHILL Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: REAGAN — Last: OVERMAN
4. DATE OF DEATH: Month: NOV — Day: 7 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-29-21
9. AGE (In years last birthday): 45 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHYSICIAN
10b. KIND OF BUSINESS OR INDUSTRY: RESEARCH N.I.H.
11. BIRTHPLACE (State or foreign country): Marian, Indiana
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: I. J. Overman
14. MOTHER'S MAIDEN NAME: Elizabeth BESSIE M SEEGAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife — Address: Same as Item 2. — Natalie M. Overman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Coronary Arteriosclerosis — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bethesda, Md.
22. DATE SIGNED: Nov. 1, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-13-67
23c. NAME OF CEMETERY OR CREMATORY: Gettysburg, Natl Cem.
23d. LOCATION (City or Town) (County) (State): Gettysburg, Penna.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: NOV 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15693 — 15694

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home 901 Arcola Ave

2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2016 Oglethorpe Street
e. IS RES DENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Marion — Middle: Stewart — Last: Owen
4. DATE OF DEATH: Month: November — Day: 6 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Caus.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1/30/1893
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State, or foreign country): Worcester, Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ralph Edward Stewart
14. MOTHER'S MAIDEN NAME: Nettie Jane White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 265-14-6988A
17. INFORMANT: Priscilla Nakamura — Address: 11133 Dewey Road Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Retrolium cell Sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 5 mos.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/13, 1967, to 11/6, 1967, that (I) (we) last saw the deceased alive on 11/5, 1967, and that death occurred at 1 A M, from causes and on the date stated above

22a. SIGNATURE: Myron L. Linkin M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/6/67
22c. PHYSICIAN'S NAME (Type): Myron L. Linkin M.D.
22d. ADDRESS: 2309 Shorefield Road Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Central Cemetery
23d. LOCATION (City or Town) (County) (State): Malbury, Mass.
24. FUNERAL DIRECTOR: Glen C. Carter Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. RECD BY REGISTRAR DATE: NOV 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15700 — 35885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8604 Springdell Place

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 8604 Springdell Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: Teresa — Last: Owens
4. DATE OF DEATH: Month: November — Day: 29 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 30, 1878
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George W. Owens
14. MOTHER'S MAIDEN NAME: Katie Tenley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: 213-50-0874
17. INFORMANT — Address: Louis G. Owens, Nephew, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Arteric-sclerosis — Undetermined
DUE TO (c): Generalized Arterio-Sclerosis — Undetermined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1954 to Nov 29, 1967, that (I) (we) last saw the deceased alive on Nov 25 1967, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: George L Esall — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 29. 1967
22c. PHYSICIAN'S NAME (Type): George L Esall
22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/1/67
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons, 5130 Wisconsin Ave, NW, Washington, D.C.
25a. REC'D BY REGISTRAR — DATE: DEC 4 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
2DM 1/65

Items 18&21 Film 396
12-18-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15707 — 15696

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VRM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland	b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney	c. LENGTH OF STAY IN: D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookeville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital		d. STREET ADDRESS: RFD#I, Box 4D	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ARTHUR	ALBERT	PACK, Jr.	November	27	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White		Feb. 23, 1916	51 yrs 51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mfgrs. Representative	UPCO	Washington, D.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arthur Albert Pack	Fannie Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	578-01-0980	Medical Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Coronary artery heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Essential Hypertension

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o'clock a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Belden R. Reap, M.D.

22. DATE SIGNED: Wheaton (City or town, or county) Nov. 27, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-29-67	Woodside	Brinklow Mont. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis H. Barber	Laytonsville, Md.	NOV 29 1967	Charles Judge

VR A1SME (S) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

25702 — 15697

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 16 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM + HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: MD. — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9314 WIRE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES — Middle ADELAIDE — Last PARKER
4. DATE OF DEATH: Month NOVEMBER — Day 12 — Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 13, 1878
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): CANADA
12. CITIZEN OF WHAT COUNTRY? AMERICA
13. FATHER'S NAME: FREDERICK R. SMITH
14. MOTHER'S MAIDEN NAME: ? FRANCES TAYLOR
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: GORDON S. PARKER-SON-SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
4-12 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paroxs C.V.A - Hip fracture 16 days before
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II in item 18.): Fell at Home on 10-24-67
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 10-24-67
20d. INJURY OCCURRED White at work ☐ Nat White at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Silver Spring (County) Mont. (State) Md.

21. I certify that (I) (this hospital) attended the deceased from 10-25, 19 67 to 11-12, 19 67 that (I) (we) last saw the deceased alive on 11-12 19 67, and that death occurred at 10:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: John W. M Roberts — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11-13-67
22c. PHYSICIAN'S NAME (Type): J.W. McRoberts, M.D.
22d. ADDRESS: 1400 Spring St S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/16/67
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
23d. LOCATION (City or town) Arlington (County) (State) Va.

24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawlerstone, Inc. Wash. D.C.
25a. RECD BY REGISTRAR DATE: NOV 20 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15703 Item #4 Film #3395 11/30/67 ph

CERTIFICATE OF DEATH

15098

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park c. LENGTH OF STAY IN 1b: 39 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.	d. STREET ADDRESS: 7513 Maple Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Edith (NMN) Middle Parsons Last	4 DATE OF DEATH: Month Nov. Day 20 Year 19 67							
5 SEX: Fe	6 COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: ~~July 20~~ July 1896	9 AGE (In years last birthday): 71 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired school teacher	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country): Newfoundlan Canada	12. CITIZEN OF WHAT COUNTRY? Amer.					
13. FATHER'S NAME: Adolphus Yates	14. MOTHER'S MAIDEN NAME: Elizabeth Moores							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 584-22-6832	17 INFORMANT: Med. Record	Address: W.S.H.					

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): massive CVA — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(b): Severe Generalized Arteriosclerosis — 8-10 yrs.

DUE TO

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this ~~hospital~~) attended the deceased from Jan 65, 19 65, to Nov 20, 19 67, that (I) (~~we~~) last saw the deceased alive on Nov 19 19 67, and that death occurred at 2:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: R. H. Sandstrom M.D.	M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED: 11/20/67	
22c. PHYSICIAN'S NAME (Type): R. H. Sandstrom MD	22d. ADDRESS: 7291 Carroll Av Takoma Park Md		

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF: Nov 24 1967	23c NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery	23d LOCATION (City or Town): Kensington	(County): Montg. (State): Md.
24. FUNERAL DIRECTOR: Gibbs-Dalton	ADDRESS: 254 Carroll St. NW (WASH. D.C.)	25a RECD BY REGISTRAR DATE: NOV 27 1967	25b REGISTRAR'S SIGNATURE: Charles Judge	

1

15704

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15999

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) — a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 1515 EASKINE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: BENJAMIN — Last: PARSONS

4. DATE OF DEATH: Month: NOVEMBER — Day: 8 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-30-05

9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ADMINISTRATIVE ASSISTANT
10b. KIND OF BUSINESS OR INDUSTRY: Federal Government
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON D.C.
12. CITIZEN OF WHAT COUNTRY?: AMERICA

13. FATHER'S NAME: JOHN PARSONS
14. MOTHER'S MAIDEN NAME: DUNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W.W. II
16. SOCIAL SECURITY NO: 579 58 3007
17. INFORMANT — Address: PATIENT'S CHART

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO (b): Myocardial Infarction
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pleural Effusion; Bronchial Pneumonia; Hypostatic Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 10-19-1967, to 11-8, 1967, that (I) (we) last saw the deceased alive on 11-8-1967, and that death occurred at 12:40 P M, from causes and on the date stated above.

22a. SIGNATURE: Alan R Gair M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-8-67.
22c. PHYSICIAN'S NAME (Type): ALan R. Gair M D
22d. ADDRESS: 7777 Maple Ave, Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 11. 1967
23c. NAME OF CEMETERY OR CREMATORY: Parkdown Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville Md.

24. FUNERAL DIRECTOR — ADDRESS: J. Arthur Walters, 254 Carroll Ave. Takoma Park 12
25a. REC'D BY REGISTRAR — DATE: NOV 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

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15705

15700

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 9119 Marseille Dr. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maude — Middle: M — Last: Penn

4. DATE OF DEATH: Month: 11 — Day: 28 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-29-879

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace Murphy

14. MOTHER'S MAIDEN NAME: Charlotte Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Daughter — Address: Same as Item 2.
Lottie Goldsborough

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Pyelonephritis, chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-20, 19 67, to 11-28, 19 67, that (I) (we) last saw the deceased alive on 11-28-1967, and that death occurred at 8p M, from causes and on the date stated above.

22a. SIGNATURE: Robert C. Daddario — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/29/67

22c. PHYSICIAN'S NAME (Type): ROBERT C. DADDARIO

22d. ADDRESS: 5413 CEDAR LANE BETHESDA

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-1-67

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cath. Cem.

23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: DEC 4 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

1

15708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2b Film #G395 12/7/67 mb

CERTIFICATE OF DEATH

15701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 6 years

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Asbury Methodist Home for the Aged, Inc.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lula; Middle May; Last Pickett
4. DATE OF DEATH: Month Nov; Day 26; Year 19 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 24, 1871
9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Carroll County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph James Brandenburg
14. MOTHER'S MAIDEN NAME: Mary Jane Dronenburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-54-7947-T
17. INFORMANT: Address: Asbury Methodist Home, Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b): Arteriosclerotic Heart Disease — 6 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/1/63, 19__, to 11/26/67, 19__, that (I) (we) last saw the deceased alive on 11/24/67, 19__, and that death occurred at 1245P M, from causes and on the date stated above.

22a. SIGNATURE: Henry C. Sevigos MD — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/26/67
22c. PHYSICIAN'S NAME (Type): HENRY C. SEVIGOS MD
22d. ADDRESS: 5413 Cedar Lane Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-28-67
23c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel
23d. LOCATION (City or Town) (County) (State): Woodbine Md.

24. FUNERAL DIRECTOR: Gartner's Funeral Home — ADDRESS 316 E. Diamond Ave
Forte H. Sandison Gartner
FORTE H. SANDISON
25a. REC'D BY REGISTRAR — DATE NOV 28 1967
25b. REGISTRAR'S SIGNATURE: Marion Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15707 — 15702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N.W. Washington
d. STREET ADDRESS: 5331 42nd. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: Frost — Last: Reedon
4. DATE OF DEATH: Month: Nov. — Day: 8 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-28-78
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Electroplater
10b. KIND OF BUSINESS OR INDUSTRY: Metal Finishing
11. BIRTHPLACE (County & State or foreign country): London, England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1898
16. SOCIAL SECURITY NO.: 578-03-3534
17. INFORMANT: G. Reedon 5331 Address 42nd. St. Arthur-Son - N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Papillary carcinoma, Urinary Bladder

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct 30, 1967, to Nov. 8, 1967, that (I) (~~we~~) last saw the deceased alive on Nov 8 1967, and that death occurred at 6:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: Lee M. Curtis — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Nov. 8, 1967
22c. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-11-1967
23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.
ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. RECD BY REGISTRAR DATE: NOV 13 1967
25b. REGISTRAR'S SIGNATURE: Juliana Jungo

H 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15708

CERTIFICATE OF DEATH

15703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 19 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ADELPHI
d. STREET ADDRESS: 8714 - 23RD AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHESTER — Middle — Last PLACHTA
4. DATE OF DEATH: Month 11 — Day 19 — Year 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/8/1915
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NAVY DEPT WORKER (SITE PLANNER)
10b. KIND OF BUSINESS OR INDUSTRY: NAVY DEPT.
11. BIRTHPLACE (County & State, or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Plachta
14. MOTHER'S MAIDEN NAME: Anna Grohny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service): yes WW II
16. SOCIAL SECURITY NO: 134-12-6827
17. INFORMANT: Eleanor M. Plachta — 8714 Address 23rd Avenue Adelphi, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Reticulum Cell Sarcoma — 4 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2000

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug, 1967, to 11/19, 1967, that (I) (we) last saw the deceased alive on 11/13, 1967, and that death occurred at 4:10 A.M., from causes and on the date stated above

22a. SIGNATURE: G. Leonard Gold M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 11/19/67
22c. PHYSICIAN'S NAME (Type): G. Leonard Gold
22d. ADDRESS: 9801 Georgia Avenue, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: John B. Thomas — Harner E. Pumphrey, Inc. — 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: NOV 22 1967
25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15703 15704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg Md.
c. LENGTH OF STAY IN 1b 1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pleasant View Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 5510 Lincoln Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle BOSWELL Last Poole
4. DATE OF DEATH Month 11 Day 25 Year 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 1/7/1881
9. AGE (In years last birthday) 86 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Lawson Poole
14. MOTHER'S MAIDEN NAME Elizabeth Boswell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO 577-05-1970
17. INFORMANT Nephew Address 6013 Berkshire Drive
W. R. Poole Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Failure
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Atherosclerotic Cardiovascular Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Tuberculosis, quiescent
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-26 —, 1967, to 11-25-67, 19___, that (I) (we) last saw the deceased alive on 11-23- 1967, and that death occurred at 7:15 AM, from causes and on the date stated above.

22a. SIGNATURE Milton D. Westberg M.D.
M.O. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 11-25-67
22c. PHYSICIAN'S NAME (Type) Milton D. Westberg M.D.
22d. ADDRESS 431 N. Frederick Ave Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 11-27-67
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State) Prince George County, Md.

24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 4 1967
25b. REGISTRAR'S SIGNATURE [illegible] Judge

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and/or 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15710

CERTIFICATE OF DEATH

15705

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 10109 BRUNETT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HILDA — Middle: R. — Last: POWELL
4. DATE OF DEATH: Month: 11 — Day: 19 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/5/95
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Texas.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Reynolds
14. MOTHER'S MAIDEN NAME: Katherine Rolls

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Ernest F. Kieffer — Address: 10109 Brunett Avenue Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): MASSIVE GASTRO-INTESTINAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 6 HRS
DUE TO
(b): RUPTURED ESOPHAGEAL VARICES — 6 HRS
DUE TO
(c): PORTAL CIRRHOSIS OF LIVER — 10+ YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CONGESTIVE HEART FAILURE

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAM.NER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from MAY, 1960, to NOV 19, 1967, that (I) ~~(he)~~ last saw the deceased alive on NOV 19 1967, and that death occurred at 1:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Edward A. Beeman M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: NOV 19, 1967
22c. PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN
22d. ADDRESS: 1015 SPRING ST, SILVER SPRING MD 20910

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-Burial
23b. DATE THEREOF: Nov. 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park, Inc.
23d. LOCATION (City or Town) (County) (State): New Orleans, La.

24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: NOV 22 1967
25b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15711

CERTIFICATE OF DEATH

15706

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 6 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Monty.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville — 15-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EMMA — Middle: W. — Last: Pyles

4. DATE OF DEATH: Month: November — Day: 11 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1-4-79

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Monty - Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John A. Williams

14. MOTHER'S MAIDEN NAME: Sarah White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: 217-48-8592

17. INFORMANT Address: Mrs. Riggs Darby Boyds, Md -

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of uterus & rectum — Interval between onset and death: 2 years.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1247

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile atherosclerosis & osteoarthritis - 5 years.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June, 1962 to Nov. 11, 1967 that (I) ~~(we)~~ last saw the deceased alive on Nov 11, 1962, and that death occurred at 8:40 A.M. from causes and on the date stated above.

22a. SIGNATURE: W. A. Linthicum — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/11/67

22c. PHYSICIAN'S NAME (Type): W. A. Linthicum

22d. ADDRESS: 110 S. Washington St. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/14/67

23c. NAME OF CEMETERY OR CREMATORY: Monocacy

23d. LOCATION (City or Town) (County) (State): Beallsville Monty. Md

24. FUNERAL DIRECTOR: Constance C. Hilton — ADDRESS: Barnesville Md

25a. REC'D BY REGISTRAR DATE: NOV 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
PM 1/67

15712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15707

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 38 min

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: Md.
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban.

d STREET ADDRESS: 5108 Saratoga Ave N W

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Arthur — Last: Pyles

4 DATE OF DEATH: Month: Nov — Day: 21 — Year: 1967

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 11 1920

9 AGE (In years last birthday): 47 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Charles Arthur Pyles

14 MOTHER'S MAIDEN NAME: Marie Sloatter

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT: Mother — Address: Marie S. Pyles — Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial Infarction, recent & remote — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(b): Coronary arteriosclerosis with occlusion
DUE TO
(c):

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 11/22/67

Address (Street, city, town or county): Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11-25-67

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d LOCATION (City or Town) (County) (State): Suitland, Maryland

24 FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland

ADDRESS

25a RECD BY REGISTRAR DATE: NOV 27 1967

25b REGISTRAR'S SIGNATURE: Miranda Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15713

CERTIFICATE OF DEATH

15708

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): The Clinical Center, Bethesda, Maryland

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before odm ssion)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 13317 Bea Kay Drive
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harland — Middle: Christopher — Last: Randolph

4 DATE OF DEATH: Month: November — Day: 21 — Year: 19 67

5 SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 October 1967

9. AGE (In years lost birthday) yrs.: IF UNDER 1 YEAR Months: 1 Days: 19 — IF UNDER 24 HRS Hours: Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State or foreign country): Washington, D. C.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harland L. Randolph

14. MOTHER'S MAIDEN NAME: Mariam Lawson

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16 SOCIAL SECURITY NO: None

17. INFORMANT Address: The Medical Records, The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Atresia — INTERVAL BETWEEN ONSET AND DEATH: 7 Weeks
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACC DENT WAS UNDER.YING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State): 21

21. I certify that ☒ (this hospital) attended the deceased from November 15, 1967, to November 1, 1967, that ☒ (we) last saw the deceased alive on November 21 19 67, and that death occurred at 7:25 PM, from causes and on the date stated above.

22a SIGNATURE: Willis H. Williams M.D — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: Nov. 22, 1967

22c PHYSICIAN'S NAME (Type): Willis H. Williams, M.D.

22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: 11-23-67

23c NAME OF CEMETERY OR CREMATORY: Fells

23d LOCATION (City or Town) (County) (State): Washington D.C.

24 FUNERAL DIRECTOR: Robert J. Mooney — ADDRESS: 1820 [illegible] Washington D.C.

25a RECD BY REG STRAR DATE: NOV 27 1967

25b REGISTRAR'S SIGNATURE: [illegible] Judge

77021707

1

15714

15769

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Ordinance Laboratory

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
d. STREET ADDRESS: 8605 Barron Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: John Middle: (none) Last: Rebak, Jr.
4. DATE OF DEATH Month: November Day: 30 Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/19/21
9. AGE (In years last birthday): 46 yrs; IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elect. Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Govt.
11. BIRTHPLACE (County & State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Rebak
14. MOTHER'S MAIDEN NAME: Clementine Philamunchak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: UNK.
17. INFORMANT: Wife Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardiovascular Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1600 11/30 1967 to 1605 11/30 1967 that (I) (we) last saw the deceased alive on 11/30 1967, and that death occurred at 4:05 PM from causes and on the date stated above.

22a. SIGNATURE: David P. Price M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/30/67
22c. PHYSICIAN'S NAME (Type): DAVID P PRICE
22d. ADDRESS: Naval Ordnance Laboratory

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 5. 1967
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Provincetown Mass

24. FUNERAL DIRECTOR: W W Taltavull ADDRESS: 3603 14th St NW DC 20010
25a. REC'D BY REGISTRAR DATE: DEC 4 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

Coroner Dr. Reap notified and approves

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #[illegible] 11/7/67 ph

15715 Item #8 Film G-74 11/13/67 KK 15710

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural) — c. LENGTH OF STAY IN 1b: 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital	d. STREET ADDRESS: 4655 Dupont Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Paul	Dana	REED	November	3	1967

5 SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Cauc		1966 Jan. 21, 1967	1 yrs	9			

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
N/A	N/A	ROTA, SPAIN	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Raymond Reed	Mary Phillips

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT Suitland Address Maryland
No —	N/A	POC Raymond Reed, USN, 4655 Dupont Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia bilateral

DUE TO

(b) Myeloproliferative disease

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from Nov. 2, 1967, to Nov. 3, 1967, that ~~I~~ (we) last saw the deceased alive on Nov. 3 1967, and that death occurred at 1108 AM, from causes and on the date stated above.

22a. SIGNATURE Jerry J. Tomasovic M.D — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic — 22d. ADDRESS Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-6-1967	Academy Cemetery	Evansville, Arkansas

24. FUNERAL DIRECTOR W. W. Chambers Co. — ADDRESS 1400 Chapin Street, N.W., Washington, D.C.

25a REC'D BY REGISTRAR DATE NOV 6 1967 — 25b. REGISTRAR'S SIGNATURE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15716

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15711

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c LENGTH OF STAY IN 1b: D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Howard
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Savage
d STREET ADDRESS: 2114 Savage-Guilford Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Richard — Middle: D. — Last: Reeley
4 DATE OF DEATH: Month: November — Day: 7 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Jan. 4, 1911
9 AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10b KIND OF BUSINESS OR INDUSTRY: Self-Employed
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Richard Reeley
14 MOTHER'S MAIDEN NAME: Annie Gavigan

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWII
16 SOCIAL SECURITY NO:
17 INFORMANT: Medical Records — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Coronary Artery Heart Disease,
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): Belden R. Reap, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22 DATE SIGNED: Nov. 7, 1967
Address (Street, city, town, or county): 11502 Grandview Ave. Wheaton, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-10-67
23c NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
23d LOCATION (City or Town) (County) (State): Fleiffers Corner Md.

24 FUNERAL DIRECTOR: DeWitt Donaldson — ADDRESS: Laurel Md

25a REGISTRAR REGISTRATION DATE: NOV 13 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1-67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15717 15712

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland 20810
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 27 A Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earl — Middle: Ernest — Last: Rhodes

4. DATE OF DEATH: Month: November — Day: 28 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: March 8-99

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Race Tract Owner & Horse trainer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: Rhodes

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-18-2494

17. INFORMANT — Address: Patient's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Aplastic Anemia ; Associated with — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pneumonia of Right Lung — 2 wks
DUE TO
(c): and Leukopenia — 2 wks +

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pelvic Abscess

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that ~~I~~ (this hospital) attended the deceased from 11/14/67, 19___, to 11/28/67, 19___, that ~~I~~ (we) last saw the deceased alive on 11/28/67 19___, and that death occurred at 6:39 a M, from causes and on the date stated above

22a. SIGNATURE: Paul L Robb MD — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/28/67

22c. PHYSICIAN'S NAME (Type): PAUL L. ROBB, M.D.

22d. ADDRESS: 7600 CARROLL AVE, TAKOMA PARK MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-1-67

23c. NAME OF CEMETERY OR CREMATORY: Ivy Hill Cem.

23d. LOCATION (City or Town) (County) (State): Laurel Md.

24. FUNERAL DIRECTOR: [illegible] Thomas M. Laurel, Md.

25a. RECD BY REGISTRAR DATE: DEC 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15718

CERTIFICATE OF DEATH

15713

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 808 Rowen Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Charles — Middle: J. — Last: Richardson

4 DATE OF DEATH: Month: 11 — Day: 6 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
M	W	NEVER MARRIED ☒	9/5/92	75 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Produce Mgr.
10b. KIND OF BUSINESS OR INDUSTRY: D.G.S. Store
11. BIRTHPLACE (County & State, or foreign country): Montgomery Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert J. T. Richardson
14. MOTHER'S MAIDEN NAME: Alice Van Horn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 189-09-1415
17. INFORMANT: Mrs. Pete Morris — Address: 808 Rowen Road Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremic Poisoning — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b): Multiple Myeloma — 6 months
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ~~September~~ 1964 to Nov. 6, 1967, that (I) (~~was~~) last saw the deceased alive on Nov. 6, 1967, and that death occurred at 6:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: Gene Cohen M.D. — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Nov. 6, 1967
22c. PHYSICIAN'S NAME (Type): Gene U. Cohen M.D.
22d. ADDRESS: 1106 Spring St. Silver Spring MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 10 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland
24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: NOV 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

15715

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15714

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 1609 BELVADERE BLVD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SAAD — Middle: — Last: RICHEY

4. DATE OF DEATH: Month: NOV. — Day: 20 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 8/16/1896

9. AGE (In years last birthday): 83 7 Yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (County & State or foreign country): LEBANON, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Richey

14. MOTHER'S MAIDEN NAME: S. Munahoon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 173-18-7951

17. INFORMANT: George Richey — Address: 1609 Belvadere Blvd. Silver Spring, Maryland

MED. CAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Hepatic Metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO
(b): Melanoma (Primary site, skin eye) — 3 or 4 yrs
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) ~~(this hospital)~~ attended the deceased from Sept, 1967, to 11/20, 1967, that (I) ~~(we)~~ last saw the deceased alive on 11/19 1967, and that death occurred at 1:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: G. Leonard Gold — M.D — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 11/20/67

22c. PHYSICIAN'S NAME (Type): G. Leonard Gold

22d. ADDRESS: 9801 Georgia Avenue, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Sylvan Heights Cemetery

23d. LOCATION (City or Town) (County) (State): Uniontown, Pennsylvania

24. FUNERAL DIRECTOR: Carver C. Glen Carter Pumphrey, Inc. — ADDRESS: 8134 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: NOV 22 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15720 15715

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CABIN JOHN
d. STREET ADDRESS: 1 ERICSSON ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
HARVEY	HILBERT	RICKETTS	NOV	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
MALE	WHITE		6/29/08	59 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TRUCK DRIVER	CORNELLS	WASHINGTON, D.C.	U.S.A.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DAVID RICKETTS	MAUDE FISHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		VIRGINIA RICKETTS - WIFE - SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
(b) Arteriosclerosis - atherosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 22, 1966, to Nov 7, 1967, that (I) ~~(we)~~ last saw the deceased alive on Nov 7 1967, and that death occurred at 9:06 AM, from causes and on the date stated above

22a. SIGNATURE: Allen J. O'Neill M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ALLEN O'NEILL — 22d. ADDRESS: 8601 Old Georgetown Rd. Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	11-22-67	Ft. Lincoln Cem.	Prince George County, Md.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland	NOV 24 1967	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15721 — 15716

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockwood .5
d. STREET ADDRESS: Route #3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Doris — Middle: Fern — Last: Romesberg

4. DATE OF DEATH: Month: November — Day: 11 — Year: 1967

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2 October 1921

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11 BIRTHPLACE (County & State, or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Simon Enos

14. MOTHER'S MAIDEN NAME: Susan Liphart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: Not Available

17. INFORMANT: The Medical Records, The Clinical Center, Bethesda, Maryland — Address: 20014

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Metastatic Malignant Melanoma
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 30 October, 1967, to 11 Nov., 1967, that (X) (we) last saw the deceased alive on 11 November 1967, and that death occurred at 7:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Arthur J. Levine M.D. — M.D. ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]

22b DATE SIGNED: Nov. 12, 1967

22c. PHYSICIAN'S NAME (Type): Arthur J. Levine, M.D.

22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/15/67

23c NAME OF CEMETERY OR CREMATORY: Rockwood IOOF

23d LOCATION (City or Town) (County) (State): Rockwood, Pa.

24 FUNERAL DIRECTOR: [illegible] Funeral Home

ADDRESS: [illegible] Rockville Pike, Rockville, Maryland

25a REC'D BY REGISTRAR DATE: NOV 14 1967

25b REGISTRAR'S SIGNATURE: [illegible] Judge

1

15722 15717

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   - a. COUNTY: Montgomery — MARYLAND
   - b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   - c. LENGTH OF STAY IN 1b:
   - d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 401 Randolph Rd. (Holy Family Seminary)
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   - a. STATE: Maryland
   - b. COUNTY: Montgomery
   - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, MD
   - d. STREET ADDRESS: 401 Randolph Rd.
   - e. IS RESIDENCE ON A FARM? YES ☐ NO ☑
3. NAME OF DECEASED (Type or print): First: Joseph; Middle: (NMI); Last: RUENSA
4. DATE OF DEATH: Month, Day, Year: 4 Nov. 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 Feb 1883
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Priest

10b. KIND OF BUSINESS OR INDUSTRY: Church

11. BIRTHPLACE (County & State, or foreign country): Spain
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-56-4701
17. INFORMANT: Father Hoffman — Address: 401 Randolph Rd. S.S. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia - diffuse	1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Heart failure - congestive	months
DUE TO (c)	Arteriosclerotic heart disease	yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old age - rheumatoid arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1965, to Nov. 4, 1967, that (I) (we) last saw the deceased alive on Nov. 4, 1967, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard P. Delaney M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Richard P. Delaney, MD

22d. ADDRESS: 4323 Howard St. Sil. Spg. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8 Nov. 1967

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City, town or county) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Rinaldi Funeral Home Inc. — ADDRESS: 4400 Georgia Ave N.W. DC 20011

25a. REC'D BY REGISTRAR DATE: NOV 7 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15723

CERTIFICATE OF DEATH

17349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda c. LENGTH OF STAY IN 1b: 21 Days. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda d. STREET ADDRESS: 8104 Hampden Lane e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Charlotte Middle F. Lost Lippert	4. DATE OF DEATH: Month Nov. Day 29 Year 1967
5. SEX: F — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 7 Sept 1892 — 9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Vermont — 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Patrick J. Farrell	14. MOTHER'S MAIDEN NAME: Sarah Brady
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.	17. INFORMANT: Patricia L. Nelson — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Careinomatosis
DUE TO (b): Primary duct careinoma, right breast
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
170X
INTERVAL BETWEEN ONSET AND DEATH: (a) months; (b) 2 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 54 to 11-29, 19 67 that (I) (we) last saw the deceased alive on 11-29 1967, and that death occurred at 6:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Geo. A. Gray, Jr. — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: Nov 30 1967

22c. PHYSICIAN'S NAME (Type): GEORGE A. GRAY, JR. — 22d. ADDRESS: 4740 Mary Chase Drive, Chevy Chase, Md. 20015

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12-2-67 — 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemtery — 23d. LOCATION (City or town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland — 25a. REC'D BY REGISTRAR DATE: DEC 8 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
6M 1/67

5724

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

5718

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Garrett Park
d. STREET ADDRESS: 10904 Montrose Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martin — Middle: DePorres — Last: Russillo

4. DATE OF DEATH: Month: Nov — Day: 26 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1964

9. AGE (In years last birthday): 3 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul D. Russillo

14. MOTHER'S MAIDEN NAME: Castradara, Angela

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: Paul Russillo - father (did not see)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Aspiration of Gastric Content — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO
(b): Cerebral Palsy — 3 years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 11/27/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial
23b. DATE THEREOF: Nov. 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Francis Cemetery
23d. LOCATION (City or Town) (County) (State): Providence, Rhode Island

24. FUNERAL DIRECTOR: John B. Thomas, Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 1 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15725 Item 8 Film G99 11/24/67 KK

CERTIFICATE OF DEATH

15719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montg. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville - Rural
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville - Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: St. Laurent

4. DATE OF DEATH: Month: Nov. — Day: 14 — Year: 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 9/1/1876

9. AGE (In years last birthday): 91 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance.

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leon St. Laurent

14. MOTHER'S MAIDEN NAME: Celia Lessard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mrs. Laurence Abercrombie — Address: Poolesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchitis and Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from October, 1962, to 14 Nov, 1967, that (I) ~~(we)~~ last saw the deceased alive on 14 Nov 1967, and that death occurred at 9:45P M, from causes and on the date stated above.

22a. SIGNATURE: Gordon Murdoch Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 14 Nov 67

22c. PHYSICIAN'S NAME (Type): Gordon Murdoch Smith

22d. ADDRESS: Barnesville, Md., Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/17/1967

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cath.

23d. LOCATION (City or Town) (County) (State): Barnesville Monty. Md

24. FUNERAL DIRECTOR: Constance C. Hilton — **ADDRESS**: Barnesville Md

25a. REC'D BY REGISTRAR DATE: NOV 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15725 — 15720

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 6 mos - 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4856 Chevy Chase Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: H. — Last: Sasscer

4. DATE OF DEATH: Month: 11 — Day: 13 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7-4-91

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Gen. Acct. Office

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (County & State, or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: H. H. Sasscer

14. MOTHER'S MAIDEN NAME: Lieze Fitch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 220-42-1488

17. INFORMANT — Address: Harrison Sasscer, Son, Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Dehydration — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Left hemiplegia — 6 months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 2, 1967, to Nov 13, 1967, that (I) (we) last saw the deceased alive on Nov 10, 1967, and that death occurred at 8:30 A M, from causes and on the date stated above.

22a. SIGNATURE: Dr Joseph Kenrick — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/13/67

22c. PHYSICIAN'S NAME (Type): DR JOSEPH KENRICK

22d. ADDRESS: 6450 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/16/67

23c. NAME OF CEMETERY OR CREMATORY: St. Thomas Church Cem.

23d. LOCATION (City or Town) (County) (State): Croom, Maryland

24. FUNERAL DIRECTOR — **ADDRESS**: Joseph Gawler's Son Washington D C

25a. RECD BY REGISTRAR DATE: NOV 20 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15727 Item #2a,b,c & d Film 3396 12/7/67 ph

CERTIFICATE OF DEATH

15721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sylvan Manor Health Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland/ D.C. — b. COUNTY: Montgomery/ ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring/ Wash., D.C.
d. STREET ADDRESS: 815 Rue St., N.W. Cairo 2700 Block Block Hotel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gertrude — Middle A. — Last Schellhase

4. DATE OF DEATH: Month November — Day 24 — Year 1967

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 19, 1882
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (County & State, or foreign country): Evansville, Indiana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gus Schellhase
14. MOTHER'S MAIDEN NAME: Louise Mundy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: yes
17. INFORMANT: Kriehaus-Sanson Funeral Home, Address: 702 Gum Street, Evansville, Indiana

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
7201
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Coronary atherosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept, 1963, to Present, 19___, that (I)(we) last saw the deceased alive on Nov 18 1967, and that death occurred at 10:50 P M, from causes and on the date stated above.

22a. SIGNATURE: Francis Chuntera M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-25-67
22c. PHYSICIAN'S NAME (Type): FRANCIS CHUCTA M.D.
22d. ADDRESS: 2500 CALVERT ST NW WASH, DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Evansville, Indiana

24. FUNERAL DIRECTOR: John Thomas JB Thomas Harner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. RECD. BY REGISTRAR — DATE: NOV 28 1967
25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15728 — 15722

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Mont. Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d STREET ADDRESS: 6905 - Granby St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Emma — Middle: M. — Last: Schmuser
4 DATE OF DEATH: Month: Nov. — Day: 10 — Year: 19 67
5 SEX: female
6 COLOR OR RACE: white
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 12/30/88
9 AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): New Hampshire
12 CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Leonard Kuhn
14 MOTHER'S MAIDEN NAME: Julia Posselt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 220-44-2638
17 INFORMANT: JL Mrs. Herman Gaines — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular Fibrillation due to
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocardial Infarction,
DUE TO (c): Hypertension - Arteriosclerotic Heart Dis.
INTERVAL BETWEEN ONSET AND DEATH: INSTANT — 19 DAYS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteoarthritis severe
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o m. a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Sept. 19, 1958 to Nov. 10, 1967, that (I) (we) last saw the deceased alive on Nov. 10 1967, and that death occurred at 5:30 M, from causes and on the date stated above.

22a SIGNATURE: Robert G. Angle — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Nov. 10, 1967
22c. PHYSICIAN'S NAME (Type): ROBERT G. ANGLE
22d ADDRESS: 5009 Del Ray Ave. Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-14-67
23c NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d LOCATION (City or Town) (County) (State): Hammond, Indiana

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland
25a REC'D BY REGISTRAR DATE: NOV 14 1967
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15723

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): SILVER SPRING
d. STREET ADDRESS: 8201 16th ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL — Middle C. — Lost SCHOOLER

4. DATE OF DEATH: Month Nov. — Day 4 — Year 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-31-09

9. AGE (In years last birthday): 58 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morris Cohen

14. MOTHER'S MAIDEN NAME: Celia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Myron I. Weinstein — Address: 12015 Cold Stream Dr. Potomac, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c): Ruptured Saccular intracranial aneurysm — 9 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/26, 1967 to 11/4, 1967 that (I) (we) last saw the deceased alive on 11/3 1967, and that death occurred at 2:25 PM, from causes and on the date stated above.

22a. SIGNATURE: John Thomas Lord M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): John Thomas Lord

22d. ADDRESS: 1015 Spring St. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-5-67

23c. NAME OF CEMETERY OR CREMATORY: Beth Sholom Cemetery

23d. LOCATION (City or Town) (County) (State): Hillside Maryland

24. FUNERAL DIRECTOR: Bernard Danzansky AND SONS — ADDRESS: 3501-14th St. N.W. Washington, D.C.

25a. RECD BY REGISTRAR DATE: NOV 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15730

CERTIFICATE OF DEATH

15724

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 3438 Chiswick Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: — Last: Schultheis

4. DATE OF DEATH: Month: 11 — Day: 20 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/3/99

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architectrial Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Engineering

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anton Schultheis

14. MOTHER'S MAIDEN NAME: Louisa Gossweiler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 226-26-0199-A

17. INFORMANT: Elizabeth Schultheis — Address: 3438 Chiswick Ct. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): METASTATIC CEREBRAL CA — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
(b): METASTATIC KIDNEY CA. — 12 mos +
DUE TO
(c): CARCINOMA - PROSTATE — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o'm. a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/26, 19 67 to 11-19, 19 67, that (I) (we) last saw the deceased alive on 11/19/67, and that death occurred at 10:15 AM, from causes and on the date stated above

22a. SIGNATURE: [signature] MD — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/24/67

22c. PHYSICIAN'S NAME (Type): FRANCIS C MAYLE JR

22d. ADDRESS: 8218 Wisconsin Ave Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Flushing Cemetery

23d. LOCATION (City or Town) (County) (State): Flushing, New York

23e. FUNERAL DIRECTOR: C. Glen Carter, Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: NOV 24 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15731

CERTIFICATE OF DEATH

15725

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE [illegible] — COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET: The Army Listaff Hall 6200 Oregon Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Florence — Middle: L. — Last: Seaman

4. DATE OF DEATH: Month: Nov. — Day: 26 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 7/30/81

9. AGE (In last birthday) yrs: 86

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City & State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Oliver C. Look

14. MOTHER'S MAIDEN NAME: Katherine Beedle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 131-24-4708

17. INFORMANT — Address: Jonathan Seaman- Ft. Meade, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerotic heart disease — 10 yrs.
DUE TO (c):
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/25/67, to 11/26/67, that (I) (we) last saw the deceased alive on 11/26/67 and that death occurred at 0p M, from causes and on the date stated above

22a. SIGNATURE: Myron L Lenkin — M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/27/67

22c. PHYSICIAN'S NAME (Type): MYRON L. LENKIN MD

22d. ADDRESS: 2309 SHORE FIELD RD

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 11/29/67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City or Town) (County) (State): Ft. Myer, Va.

24. FUNERAL DIRECTOR: Geo. S. H. Hines — ADDRESS: 2901-14th

25a. REC'D BY REGISTRAR — DATE: NOV 30 1967

25b. REGISTRAR'S SIGNATURE: Stanley Yaeger

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15732

CERTIFICATE OF DEATH

15726

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo's Co ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ofon Hill, Maryland
d. STREET ADDRESS: 4614 Cedar Ridge Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Bertha — Last: Seitz

4. DATE OF DEATH: Month: Nov. — Day: 28 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2-25-1897

9. AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): European Lithuania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Julius Koblenz

14. MOTHER'S MAIDEN NAME: Marie Codat

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address:
Carl Seitz Husband same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Several Wks.
I200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — several years
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid Arthritis, Cushing Syndrome from Long Term Corticosteroids

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967, to November 28, 1967, that (I) (we) last saw the deceased alive on November 28 1967, and that death occurred at 3:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Stuart L. Nelson — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11-28-67

22c. PHYSICIAN'S NAME (Type): Stuart L. Nelson

22d. ADDRESS: 831- Univ. Blvd. East Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 1st, 67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill, Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland, Maryland.

24. FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Wash., D.C.
Simmons Bros. F. Home. 1661-Gd. Hope Rd. SE.

25a. RECEIVED BY REGISTRAR — DATE: DEC 1 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15733 15727

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 33 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 604 Monroe St. Apt 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Lola — Last: Sexton
4. DATE OF DEATH: Month: Nov — Day: 11 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/28/07
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Animal Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: N I H
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lark Willis
14. MOTHER'S MAIDEN NAME: Olie Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 217-30-1171
17. INFORMANT: Edith Lewis Daughter — Address: 1403 Langbrook Place - Rockville MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Emboli with infarction
DUE TO
(b): Septicemia
DUE TO
(c): Agranulocytosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myeloproliferative disorder
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from Oct 9, 1967, to 11/11, 1967, that (I) (we) last saw the deceased alive on 11/10 1967, and that death occurred at 5:30 A.M., from causes and on the date stated above

22a. SIGNATURE: J. Daniel Wilkes M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): J. Daniel Wilkes
22d. ADDRESS: 6405 Winston Drive, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/13/67
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 1231 Rockville Pike, Rockville, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15728

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): BETHESDA
c LENGTH OF STAY IN 1b: YEARS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5805 LONE OAK DRIVE

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d STREET ADDRESS: 5805 LONE OAK DRIVE
e S RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARGARET Middle M. Last SHADA
4 DATE OF DEATH: Month Nov. Day 19 Year 1967

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct 31 1920
9 AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Murtagh
14. MOTHER'S MAIDEN NAME: Elizabeth MacLear

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO:
17 INFORMANT: Husband — Address: John Shada — Same as Item 2.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary thrombosis, descending branch, left — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Advanced coronary arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: Nov 23
Address (Street, city, town, or county): Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-22-67
23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a REC'D BY REGISTRAR DATE: NOV 24 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15735 15729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Nursing Home 12325 New Hampshire Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE:
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
   d. STREET ADDRESS: 3701 16th St. N.W.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Miss Mary — Middle: E. — Last: Shearer

4. DATE OF DEATH: Month: Nov. — Day: 28, — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/2/83

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Shearer

14. MOTHER'S MAIDEN NAME: Anna V. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 579-66-2850

17. INFORMANT: T William T. Wolfrey — Address: 14701 Claude Lane Silver Spring, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterial Thrombosis Rleg — INTERVAL BETWEEN ONSET AND DEATH: 2wks

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 23, 1967, to Nov 28, 1967, that (I) (we) last saw the deceased alive on 11-23 1967, and that death occurred at 11:04 M, from the causes and on the date stated above.

22a. SIGNATURE: Bennie G. Bendlar M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-28-67

22c. PHYSICIAN'S NAME (Type): Bennie G. Bendlar

22d. ADDRESS: 10820 GA. Ave. Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): cremation

23b. DATE THEREOF: 11/30/67

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory

23d. LOCATION (City, town or county) (State): Prince Georges County, Md

24. FUNERAL DIRECTOR: The S.H. Hines Company — ADDRESS: 2901 14th St. N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: DEC 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (2)
20M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15735

CERTIFICATE OF DEATH

15730

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: 1 day
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland 20014

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Pennsylvania
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham
   d. STREET ADDRESS: Route 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Tony — Middle: Jay — Last: Sheets

4. **DATE OF DEATH**: Month: November — Day: 14 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 April 1965

9. AGE (In years last birthday): 2 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jessie Sheets, Jr.

14. MOTHER'S MAIDEN NAME: Katherine L. Cochran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Craniocervical Tumor and Abscess/ ? Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Subcutaneous hemorrhage at tracheostomy site — minutes
DUE TO
(c) Brainstem compression and displacement by tumor mass — ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from November 14, 19 67, to November 14, 1967, that ~~I~~ (we) last saw the deceased alive on November 14, 19 67, and that death occurred at 8:10 PM, from causes and on the date stated above.

22a. SIGNATURE: Paul Carbone MD — M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 15 November 1967

22c. PHYSICIAN'S NAME (Type): Paul P. Carbone, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 11/16/67

23c. NAME OF CEMETERY OR CREMATORY: Britain Presbyterian

23d. LOCATION (City or Town) (County) (State): Peach Bottom R.D. Lancaster County, Pa.

24. FUNERAL DIRECTOR: The S.H. Hines Co ADDRESS: 2901 14th St. N.W. Washington, D.C.

25a. RECD BY REGISTRAR DATE: NOV 20 1967 — REGISTRAR'S SIGNATURE: Florence Judge

Items 18-21 Film 395 MARYLAND STATE DEPARTMENT OF HEALTH
11-20-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15731

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Prince Georges
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d STREET ADDRESS: 70 Maryland Ave
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bruce — Middle: Edgar — Last: Shepley
4 DATE OF DEATH: Month: 11 — Day: 5 — Year: 1967

5 SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Jan. 13, 1917
9 AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lens Grinder
10b KIND OF BUSINESS OR INDUSTRY: Chapel Optical Co. Wash. D.C.
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Edgar Shepley
14 MOTHER'S MAIDEN NAME: Lulu Marker
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 215-16-9135
17. INFORMANT: Mrs. Eleanor Shepley, 70 Md. Ave. College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive pulmonary embolism secondary to
DUE TO (b): fractured right os calcis due to
DUE TO (c): fall.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9140
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Deceased fell at home fracturing right heel
20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 9-3 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Home
20f (City or town) (County) (State): College Park Pr.Geo. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): Belden R. Reap, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Give town or county): Hyattsville
22 DATE SIGNED: Nov. 5, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Nov. 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: Frederick Memorial Park, Frederick, Fred Co. Md.
23d LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR — ADDRESS: Paul F. Bittle, Myersville, Md.
25a RECD BY REGISTRAR DATE: NOV 7 1967
25b REGISTRAR'S SIGNATURE: Wilmer Judge

VR A15ME (5) 6M 1/67 BP

1

MARYLAND STATE DEPARTMENT OF HEALTH

15739 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
   a. COUNTY: MONTGOMERY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING.
   c. LENGTH OF STAY IN 1b: 85 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CHEVY CHASE NURSING & CONV. CENTER.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
   d. STREET ADDRESS: 8211 14th AVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: KICHI — Middle: O. — Last: SHIROISHI

4. DATE OF DEATH: Month: NOVEMBER — Day: 8 — Year: 1967

5. SEX: F

6. COLOR OR RACE: Yellow

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-20-87

9. AGE (In years last birthday): 80 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): JAPAN

12. CITIZEN OF WHAT COUNTRY? JAPAN

13. FATHER'S NAME: OKAMATSU

14. MOTHER'S MAIDEN NAME: NOT AVAILABLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address: MISS TSUGIYE SHIROISHI (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cerebral thrombosis
   DUE TO (b): Generalized arteriosclerosis
   DUE TO (c): Diabetes mellitus
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1966, 19__ to 11/8, 1967; that (I) (we) last saw the deceased alive on 11/6 19 67, and that death occurred at 1:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/8/67

22c. PHYSICIAN'S NAME (Type): MORTON SHAPIRO

22d. ADDRESS: 8107 EASTERN AVE, SILVER SP. MD

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: Nov. 11. 1967

23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CREMATORY

23d. LOCATION (City or Town) (County) (State): COLMAR MANOR MD

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 457 Carroll St. N.W. Washington DC 20012

25a. RECD BY REGISTRAR DATE: NOV 13 1967

25b. REGISTRAR'S SIGNATURE: R. Charles Judge

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15739

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15733

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
LENGTH OF STAY IN 1b: 12 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban
d. STREET ADDRESS: 1510 - Rognid Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Md. — b. COUNTY: Mont. Co.

3. NAME OF DECEASED (Type or print): First: David — Middle: H. — Last: Shober Sr.

4. DATE OF DEATH: Month: 11 — Day: 7 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/15/00

9. AGE (In years last birthday): 67 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / M.n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Peoples Drug

11. BIRTHPLACE (County & State, or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Shober

14. MOTHER'S MAIDEN NAME: Mary Baltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO: 577-30-8321

17. INFORMANT: ARNITA C. David Shober — Address: See Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): esophageal varices
DUE TO
(c): cirrhosis, liver

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21). I certify that (I) (this hospital) attended the deceased from Oct. 26, 19 67 to Nov. 7, 19 67 that (I) (we) last saw the deceased alive on Nov. 7 19 67, and that death occurred at 4:40 M, from causes and on the date stated above.

22a. SIGNATURE: Robert S. Thaddeus M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 11-8-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-10-1967

23c. NAME OF CEMETERY OR CREMATORY: Glenwood cemetery

23d LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.

25a REC'D BY REGISTRAR DATE: NOV 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1573 — 15734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 14 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
   d. STREET ADDRESS: 263 Congressional Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Randi — Middle: B. — Last: Siegel

4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 1967

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-57

9. AGE (In years last birthday): 9 1/2 yrs.
   IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Marvin Siegel

14. MOTHER'S MAIDEN NAME: NORMA RACKOWITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
    (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
    PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Brain tumor
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    DUE TO (b): —
    DUE TO (c): —
    INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY, 1966, to 11 14, 1967, that (I) (we) last saw the deceased alive on 11/13, 1967, and that death occurred at 7:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Francis C. Mayle Jr — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): FRANCIS C. MAYLE JR

22d. ADDRESS: 5218 Wisconsin Ave Bethesda MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-16-67

23c. NAME OF CEMETERY OR CREMATORY: New Montefiore Cem

23d. LOCATION (City, town or county) (State): FARMINGDALE L.I., N.Y.

24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St. N.W.

25a. REC'D BY REGISTRAR — DATE: NOV 16 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
20M 1/65

1

15741 15735

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY: MONTGOMERY, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. & HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
d. STREET ADDRESS: 6718 WEST PARK DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: ROSE Middle: (N.M.N.) Last: SINITZ

4. DATE OF DEATH Month: NOVEMBER Day: 18 Year: 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOVEMBER 20, 1890
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ISADORE CHEDAKOV
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 076-03-9186
17. INFORMANT: HOSPITAL RECORDS Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4201

		Interval between onset and death
IMMEDIATE CAUSE (a)	Coronary thrombosis with myocardial infarct	1 hr
DUE TO (b)	arteriosclerotic coronary heart disease	10 years
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from — , 1965, to Nov 18, 1967, that (I) (we) last saw the deceased alive on Nov 14 1967, and that death occurred at 9:13 PM, from causes and on the date stated above.

22a. SIGNATURE: Sydney Leventhal, M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/67
22c. PHYSICIAN'S NAME (Type): Sydney Leventhal, M.D.
22d. ADDRESS: Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: King David Memorial Garden
23d. LOCATION (City or Town) (County) (State): Falls Church, Virginia

24. FUNERAL DIRECTOR: Donald M. Stein, Hebrew Memorial Funeral Home
ADDRESS: 232 Carroll Street, N. W. Washington, D. C.

25a. REC'D BY REGISTRAR DATE: NOV 21 1967
25b. REGISTRAR'S SIGNATURE: [illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Dr. [illegible], Coroner for [illegible]

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15742 Item #4 & 21 Film 67,pn 11/13/67 pn 15736

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4-WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1004 Carson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Moses — Last: Sites

4. DATE OF DEATH: Month: Nov — Day: 2 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-30-05

9. AGE (In years last birthday): 62 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Library Consultant

10b. KIND OF BUSINESS OR INDUSTRY: Publications

11. BIRTHPLACE (County & State, or foreign country): W. Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Achim W. Sites

14. MOTHER'S MAIDEN NAME: Ruhoma Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: YES

17. INFORMANT: Geraldine B. Sites — Address: 1004 Carson Street Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b): Acute left anteroseptal myocardial Thrombosis ant. des. branch, left cor. artery
DUE TO (c): A.S.H.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/9/67 to 11/13/67, that (I) (we) last saw the deceased alive on 11/2/67, and that death occurred at 9:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: John J. Curry M.D. — M.D. ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/3/67

22c. PHYSICIAN'S NAME (Type): John J. Curry

22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Sites Cemetery

23d. LOCATION (City or Town) (County) (State): Grant County, West Virginia

24. FUNERAL DIRECTOR: J. S. Thomas Jr. Thomas Turner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: NOV 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15743 — 15737

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Kokorotte~~ Silver Spring 2 miles
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 13537 Georgia Ave #203
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: R. — Last: Smith
4. DATE OF DEATH: Month: Nov. — Day: 15 — Year: 1967

5 SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
M	White	☒ Married ☐ Never Married ☐ Widowed ☐ Divorced	6-3-18	49 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance - Adjustor
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State or foreign country): So. Th Carolina
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Robert Smith
14 MOTHER'S MAIDEN NAME: Willie Green

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: — —
17. INFORMANT — Address: Olive E. Smith - See Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive GI hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO
(b): Esophageal varicus
DUE TO
(c): Laennec's cirhosis — months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Sept, 1967 to Nov. 15, 1967, that (I) (we) last saw the deceased alive on Nov 15 1967, and that death occurred at 9 05 P.M., from causes and on the date stated above.

22a SIGNATURE: [signature] M.D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 11-16 67
22c PHYSICIAN'S NAME (Type): Abraham W. Danish
22d ADDRESS: 1106 Spring St. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-20-1967
23c NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d LOCATION (City or Town) (County) (State): Rockville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawlers Sons — 5180 Wisc. Ave. N.W. Wash. D.C.
25a REC'D BY REGISTRAR DATE: NOV 20 1967
25b. REGISTRAR'S SIGNATURE: [signature] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15744 15738

1

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Md — b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7667 MAPLE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle BEATRICE — Last Smith
4. DATE OF DEATH: Month 11 — Day 1 — Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-18-96
9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): PRACTICAL NURSE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home Housewife
11. BIRTHPLACE (County & State, or foreign country): W. VA
12. CITIZEN OF WHAT COUNTRY? AMER.

13. FATHER'S NAME: Summers L. WAGNER
14. MOTHER'S MAIDEN NAME: MARGARET GORBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 577-52-0554
17. INFORMANT: Previous Hospital Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1967 to Nov 1, 1967, that (I) (we) last saw the deceased alive on Oct 28 1967, and that death occurred at 6:50 PM, from causes and on the date stated above.

22a. SIGNATURE: James W. Whitlock M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11-1-67
22c. PHYSICIAN'S NAME (Type): James W. Whitlock
22d. ADDRESS: 7717 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial
23b. DATE THEREOF: Nov. 3, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bluemont Cemetery
23d. LOCATION (City or Town) (County) (State): Grafton, West Virginia

24. FUNERAL DIRECTOR: Harner C. Glen Carter — ADDRESS: 8434 Georgia Avenue Harner C. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: NOV 3 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Cleared by Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15745

CERTIFICATE OF DEATH

15739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital,

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 219 Hanover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: B. — Last: SMITH

4. DATE OF DEATH: Month: November — Day: 22 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1893

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Medford, Massachusetts

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Bresnahan

14. MOTHER'S MAIDEN NAME: Elizabeth Finnegan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-30-7362

17. INFORMANT: Newport — Address: R. I.
CDR R. H. Smith, 50 Everett Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemorrhage massive, basillary artery
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1967 to Nov. 22, 19 67 that (I) (we) last saw the deceased alive on Nov. 22 19 67, and that death occurred at 1100 P.M., from causes and on the date stated above.

22a. SIGNATURE: Rose B Moquin
M.D ☐ ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: Nov. 24, 1967

22c. PHYSICIAN'S NAME (Type): Cdr R. B. Moquin, USN

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Joseph Gawler's Sons ADDRESS: 5130 Wisconsin Ave., N.W., Washington, D.C.

25a. REC'D BY REGISTRAR DATE: DEC 4 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15743 15740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2204 Luzerne Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2204 Luzerne Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LORENZO Middle G. Last SMITH
4. DATE OF DEATH: Month NOV Day 10 Year 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 28, 1891
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: G. A. C.
11. BIRTHPLACE (County & State, or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James W. Smith
14. MOTHER'S MAIDEN NAME: Lucy Jordan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) W. W. 1
16. SOCIAL SECURITY NO: 216-46-4428
17. INFORMANT: Mrs. Cora Smith — Address: 2204 Luzerne Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mo
DUE TO
(b) ASHD — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
#300

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma prostate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-15, 1965, to 11-10, 1967, that (I) (we) last saw the deceased alive on 11-4 1967, and that death occurred at 4:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: G. H. Sengstack M.D. M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11-10-67
22c. PHYSICIAN'S NAME (Type): George F. Sengstack
22d. ADDRESS: 9241 Columbia Blvd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: Nov 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Geo County, Md.

24. FUNERAL DIRECTOR: Joseph Gawlers Sons — ADDRESS: 5130 Wisc. Ave. N. W. Wash D. C.
25a. REC'D BY REGISTRAR DATE: NOV 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15747 15741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 (M)

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: Yrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4915 River Road

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b COUNTY: Montg.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 15-1
d STREET ADDRESS: 4915 River Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First STELLA Middle MAY Last SOLYOM

4. DATE OF DEATH: Month Nov. Day 14 Year 1967

5 SEX: F
6 COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1884
9 AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Missouri
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank A. Barbour
14 MOTHER'S MAIDEN NAME: Mary Goodin

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO.
17 INFORMANT Address: Mrs. Phyllis Lane, Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO
(b): arteriosclerotic cardiovascular disease — years
DUE TO
(c):

4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March, 1962 to 14 Nov., 1967 that (I) (we) last saw the deceased alive on 10 Nov., 1967 and that death occurred at 8:45 AM, from causes and on the date stated above.

22a SIGNATURE: Maesimund B. Panos, M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 14 Nov 67
22c. PHYSICIAN'S NAME (Type): Maesimund B. Panos, M. D.
22d ADDRESS: 1726 Eye St., N. W., Suite 513-20006

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b DATE THEREOF: 11/15/67
23c NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d LOCATION (City or Town) (County) (State): Bladensburg, Md.

24. FUNERAL DIRECTOR: Jos. Gawler's Sons
ADDRESS: 5130 Wis. Ave., N.W., Washington, D.C.
25a. REC'D BY REGISTRAR DATE: NOV 20 1967
25b REGISTRAR'S SIGNATURE: Charles Jones

D 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15742

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 621 Azalia Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: C — Last: Sonner
4. DATE OF DEATH: Month: Nov. — Day: 30 — Year: 19 67
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 4/14/99
9. AGE (In years last birthday): 68 yrs
If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accident Investigation
10b. KIND OF BUSINESS OR INDUSTRY: CAB
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse L. SONNER
14. MOTHER'S MAIDEN NAME: Ada M Cooney
15. EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) If yes, give war or dates of service: WWI Army
16. SOCIAL SECURITY NO: 151-07-4105A
17. INFORMANT: Stephen Sonner (Son) — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Insufficiency. Acute — INTERVAL BETWEEN ONSET AND DEATH: Several days
DUE TO (b): Cardio Vascular Disease — Years.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): 11/31/67 MONTG. Co., MD.
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 12/2/67
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY
23d. LOCATION (City or Town) (County) (State): SUITLAND, MD.

24. FUNERAL DIRECTOR: JOS. GAWLER'S SONS — ADDRESS: 5130 WIS. AVE, NW WASHINGTON, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15749 — 17374

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5R)
6M 1/67

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): ~~SILVER SPRING~~ Takoma Park
c. LENGTH OF STAY IN 1b: XXXXXX
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital — ~~9119 MANCHESTER RD.~~

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9119 MANCHESTER Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First WALTER — Middle (NMN) — Last SPANGENBERG

4 DATE OF DEATH: Month 11 — Day 30 — Year 1967

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug 1, 1898

9 AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manufacturers Rep.

10b KIND OF BUSINESS OR INDUSTRY: Twin Disc. Inc.

11 BIRTHPLACE (State or foreign country): Brooklyn New York

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frederick Spangenberg

14 MOTHER'S MAIDEN NAME: Bertha Frolick

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W.W. I

16. SOCIAL SECURITY NO: 577-05-3017

17. INFORMANT: Address: Walter Spangenberg JR. 7902 Falstaff Rd. McLean Va.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city or town, or county): Wheaton

22. DATE SIGNED: Nov. 30, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: Dec. 1, 1967

23c NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

23d LOCATION (City or Town) (County) (State): Princes Georges Co. Md.

24 FUNERAL DIRECTOR: John B. Thomas Funeral Director, Warner E. Humphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a REC'D BY REGISTRAR DATE: DEC 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15750 — 15743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 weeks

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Washington D.C.
b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~120 C St. NE~~
d. STREET ADDRESS: 5315 - Connecticut Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Althea Woodland Nursing Home

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Mary	Frances	Spaulding		11	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		1-23-1903	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Real Estate	Mass.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Pitchard	Annie Kidney Pitchard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Mrs. Pearl Burnham.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Failure	24 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 years
DUE TO (c)	Arteriosclerosis Generalized	15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia Secondary, Nutritional — 1 year; Polyarthritis 30 yrs. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (~~this hospital~~) attended the deceased from October 23, 1967, to Nov. 19, 1967, that (I) (~~we~~) last saw the deceased alive on Nov. 17, 1967, and that death occurred at 10 HR P M, from the causes and on the date stated above.

22a. SIGNATURE: Walcutt W. Gibson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: November 19, 1967

22c. PHYSICIAN'S NAME (Type): Walcutt W. Gibson — 22d. ADDRESS: 4300 St. Barnabas Road Marlow Heights, Maryland 20031

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	11-22-1967	Cedar Hill Cemetery	Suitland, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 Wisc. Ave., N.W. Wash. D.C. 20016	NOV 24 1967	J. Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15751 — 15744

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 4mo - 24 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): FAIRLAND NURSING HOME 2101 FAIRLAND

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: DISTRICT of COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C.
d. STREET ADDRESS: 4904 COLESTREET STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WALTER — Middle: O — Last: SPORI

4 DATE OF DEATH: Month: NOVEMBER — Day: 20 — Year: 1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
MALE	WHITE	MARRIED ☒	11/27/1890	76 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION SUPT.
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (County & State, or foreign country): CHICAGO - ILLINOIS
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Jacob SPORI
14. MOTHER'S MAIDEN NAME: Anna Barbara Segasman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service): —
16 SOCIAL SECURITY NO.: 579-07-0710A
17 INFORMANT: Bertha L. SPORI — Address: WASH D.C. 3050 "K" ST. N.W.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Cerebral arteriosclerosis — 1 yr
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. , 1966, to DECEMBER 1967 that (I) (we) last saw the deceased alive on 11/20 1967, and that death occurred at 10 AM, from causes and on the date stated above

22a SIGNATURE: Raymond T. Benack MD — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Raymond T. Benack MD
22d. ADDRESS: 4115 Colie Dr. Wheaton, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-22-1967	Cedar Hill Cemetery	Suitland, Md.

24 FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: NOV 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Quarles

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

5752 Item 9 Filed 12/1/67 KK

CERTIFICATE OF DEATH

13745

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 306 Marvin Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alexander; Middle: ; Last: STEELE

4. DATE OF DEATH: Month: November; Day: 25; Year: 1967

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 13, 1873

9. AGE (In years last birthday): 93/94 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Disbursing Officer U.S. Navy Dept.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pennsylavania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Alexander Steele

14. MOTHER'S MAIDEN NAME: Mary Gallaher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes, Spanish American WWI

16. SOCIAL SECURITY NO.: 220 44 47 81

17. INFORMANT: Mrs. Charlotte Donnan, 306 Marvin Drive — Address: Silver Spring Md. Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, prostate
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov. 13, 1967, to Nov. 25, 1967, that (I) (we) last saw the deceased alive on Nov. 25, 1967, and that death occurred at 3:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: James L Snyder — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: Nov. 27, 1967

22c. PHYSICIAN'S NAME (Type): James L. Snyder, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: W. E. Pumphrey Funeral Home — ADDRESS: 8434 Georgia Ave., Silver Spring, Md. — John B. Thornton

25a. RECD BY REGISTRAR DATE: DEC 1 1967

25b. REGISTRAR'S SIGNATURE: Edwin Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15753 — 15746

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/68

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): [illegible] HOME

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: [illegible] — b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NE WASHINGTON
d. STREET ADDRESS: 5530 Chillum
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle JAMES Last [illegible]
4. DATE OF DEATH: Month 11 Day 16 Year 1967
5. SEX: M
6. COLOR OR RACE: NEGRO
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: [illegible]
9. AGE (In years last birthday): [illegible] yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO.: 574-54-7014
17. INFORMANT: Dorothy Johnson — Address: 5530 Chillum

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Cerebral atrophy
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct 23, 1967, to Nov 11, 1967, that (I) (we) last saw the deceased alive on Nov 16, 1967, and that death occurred at 1SA M, from causes and on the date stated above.

22a. SIGNATURE: Myron L. Lenker M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 12/67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/20/67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park Maryland
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: John T. Stewart — ADDRESS: 4001 Stewart Funeral Home Benning Rd.
25a. REC'D BY REGISTRAR DATE: NOV 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15754 — 23747

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 611 Janneys Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth — Middle: Speicher — Last: STIRLING

4. DATE OF DEATH: Month: November — Day: 14 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 22 1909

9. AGE (In years last birthday): 60 57 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Accident, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry M. Speicher

14. MOTHER'S MAIDEN NAME: Sadie Gnegy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 224 58 6475

17. INFORMANT: Alexandria — Address: Virginia
Mr. James Sterling, 611 Janneys Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Infarction — INTERVAL BETWEEN ONSET AND DEATH
410 X
DUE TO (b): Left mitral thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): mitral stenosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov. 8, 1967, to Nov. 14, 1967, that (I) (we) last saw the deceased alive on Nov. 14 1967, and that death occurred at 1:10 PM, from causes and on the date stated above.

22a. SIGNATURE: L. W. Raymond — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: Nov. 15, 1967

22c. PHYSICIAN'S NAME (Type): L. W. Raymond

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-17-67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR ADDRESS: Everly-Wheatley Funeral Home
1500 West Braddock Road, Alexandria, Va.

25a. REC'D BY REGISTRAR DATE: NOV 17 1967

25b. REGISTRAR'S SIGNATURE: Helen Cy Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15755

CERTIFICATE OF DEATH

15748

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6315 Pe. Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Constance — Middle: Stoppel — Last:
4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-6-81
9. AGE (If years, last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Kuehner
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Daughter — Address: Same
Margaret Pettypher.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Biliary cirrhosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Intrinsic obstruction, common bile duct — 26 days
DUE TO
(c): Biliary calculi — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Uremia due to bilateral pyonephrosis.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 67 to Nov 10, 1967 that (I) (we) last saw the deceased alive on Nov 10 1967, and that death occurred at 10 A.M. from causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 10, 1967
22c. PHYSICIAN'S NAME (Type): ROBERT N. COALE
22d. ADDRESS: 4429 Bradley Lane, Chevy Chase Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-13-67
23c. NAME OF CEMETERY OR CREMATORY: Westminister Cemetery
23d. LOCATION (City or Town) (County) (State): Philadelphia, Penna.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland
ADDRESS
25a. REC'D BY REGISTRAR DATE: NOV 14 1967
25b. REGISTRAR'S SIGNATURE: Edwards Jr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15756 — 15749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ednor
d STREET ADDRESS: 1202 Ednor Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: David — Middle: Vernon — Last: Strand
4 DATE OF DEATH: Month: November — Day: 7th — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: September 7, 1945
9 AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SP - 4 - E - 4
10b KIND OF BUSINESS OR INDUSTRY: U.S. Army
11 BIRTHPLACE (State or foreign country): California
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Vernon Strand
14. MOTHER'S MAIDEN NAME: Alma Conrad

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes Ap. 4, '66 - '67
16 SOCIAL SECURITY NO:
17 INFORMANT: Address: Henry V. Strand 1202 Ednor Lane Ednor, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple extreme Injuries
DUE TO (b): including fractured skull.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II above.): Deceased alone ran off road and struck tree demolishing auto.
20c. TIME OF INJURY Month, Day, Year: 2:55 pm 11-7 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f (City or town) (County) (State): Silver Spring Mntgm. Md

21 I certify that I took charge of the remains described above, held an [redacted] Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Beldon R. Reap M.D.
EXAMINER'S NAME (Type): Beldon Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street and No. or town or county): Rockville
22. DATE SIGNED: Nov. 8, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/9/67
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
23d LOCATION (City or Town) (County) (State): Arlington, Arlington, Va.

24 FUNERAL DIRECTOR: C. Glen Carter
ADDRESS: Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S.
25a REC'D BY REGISTRAR DATE: NOV 10 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15757

CERTIFICATE OF DEATH

15750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Randolph Hills Nursing Home 401 Randolph Rd Wheaton

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 11506 ALMA Street.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY Middle FARR Last TALBOT
4. DATE OF DEATH: Month 11 Day 18 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 12-10-89 ~~12-5-89~~
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON DC.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: McCARTHY FARR
14. MOTHER'S MAIDEN NAME: EMMA BELLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 578-18-7589 A
17. INFORMANT: Mrs. Dorothy Buckler, Daughter Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease - — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO (b): Congestive heart failure
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/24, 1967 to 11/18, 1967, that (I) (we) last saw the deceased alive on 11/18/1967, and that death occurred at 4p M, from causes and on the date stated above

22a. SIGNATURE: Myron L Lenken M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/67
22c. PHYSICIAN'S NAME (Type): Myron L. Lenken, M. D.
22d. ADDRESS: 2390 Glenmont Cir, Wheaton Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/21/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR ADDRESS: Joseph Gawler's Sons, Inc., Wash., D. C.
25a. REC'D BY REGISTRAR DATE: NOV 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15752 15751

1

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Virginia — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural) — c. LENGTH OF STAY IN 1b: 27 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital	d. STREET ADDRESS: 8415 Stonewall Drive — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Jane	Middle: Eaton	Last: TATE	4. DATE OF DEATH	Month: November	Day: 16 — Year: 19 67
5. SEX: Female	6. COLOR OR RACE: Cauc	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: March 29, 1925	9. AGE (In years last birthday): 42 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: N/A	11. BIRTHPLACE (County & State, or foreign country): Norton, Virginia	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Harry Eaton	14. MOTHER'S MAIDEN NAME: Carmen O'Conner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16. SOCIAL SECURITY NO: 406-24-3328	17. INFORMANT: Capt. Benjamin Tate, USN, 8415 Stonewall Drive, Vienna Va. (Address)			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a): Carcinoma of the lung with wide spread metastasis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct. 20, 1967, to Nov. 16, 19 67 that (I) (we) last saw the deceased alive on Nov. 16 1967, and that death occurred at 6:20 P M, from causes and on the date stated above.

22a. SIGNATURE: Lawrence W. Raymond M.D.	ATTENDING PHYS ☐	MED. DIRECTOR ☒	STAFF PHYS. ☐	22b. DATE SIGNED: Nov. 17, 1967
22c. PHYSICIAN'S NAME (Type): Lawrence W. Raymond	22d. ADDRESS: Naval Hospital, Bethesda, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 11/21/67	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION (City or Town) (County) (State): Arlington, Va.
24. FUNERAL DIRECTOR: Money & King Funeral Home — ADDRESS: 171 Maple Ave., West, Vienna, Virginia	25a. REC'D BY REGISTRAR DATE: NOV 20 1967	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15759

CERTIFICATE OF DEATH

15752

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2817 - Nicholson St. #102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sterling — Middle: Otis — Last: Taylor

4. DATE OF DEATH: Month: November — Day: 22 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 8, 1902
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Carroll Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morris C. Taylor
14. MOTHER'S MAIDEN NAME: Fannie E. Eckaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 577-07-5216
17. INFORMANT: Glen Taylor, 7 Orchard Ave. Address: Newark Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST
DUE TO (b):
DUE TO (c): MYOCARDIAL INFARCTION.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: (a) UNKNOWN / (b) / (c) 2 weeks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from May, 1959 to Nov 22, 1967, that (I) ~~(we)~~ last saw the deceased alive on Nov 21 1967, and that death occurred at 6:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: Robert B. Irey, M.D.
ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-22-67
22c. PHYSICIAN'S NAME (Type): ROBERT B. IREY
22d. ADDRESS: 11161 New Hampshire Ave., S.S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-25-67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cem.
23d. LOCATION (City or Town) (County) (State): Colmar Manor, P.G.C. Md.

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 300 - 4½ St. N.E.
25a. REC'D BY REGISTRAR DATE: NOV 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15753

CERTIFICATE OF DEATH

15760

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN Tb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 24 Westwood Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Thompson Last:
4. DATE OF DEATH Month: 11 Day: 29 Year: 1967

5. SEX: M
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-28-22
9. AGE (In years last birthday): 45 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Thompson
14. MOTHER'S MAIDEN NAME: Georgie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II
16. SOCIAL SECURITY NO
17. INFORMANT: W.E. Ellis Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fatty cirrhosis (Metamorphosis) liver, marked.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/27, 19 67, to 11/29/67, that (I) (we) last saw the deceased alive on 11/29/67 19, and that death occurred at 7:10 P M, from causes and on the date stated above.

22a. SIGNATURE: Frederick Caldwell M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/29/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Dec. 3, 1967
23c. NAME OF CEMETERY OR CREMATORY: John Wesley Cemetery
23d. LOCATION (City or Town) (County) (State): Clarksburg, Montg. Md.
24. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville, Md.
25a. RECEIVED BY REGISTRAR DATE: DEC 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jarboe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages) 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

15761

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #3357 11/22/67 ph

CERTIFICATE OF DEATH

15754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Mong.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville c. LENGTH OF STAY IN 1b: 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 930 Veirs Mill Road	d. STREET ADDRESS: 930 Veirs Mill Rd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Leland Middle: H. Last: True	4. DATE OF DEATH: Month: 11 Day: 19 Year: 19 67
5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: 12/9/1895 9. AGE (In years last birthday): 71 yrs IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 10b. KIND OF BUSINESS OR INDUSTRY: Farm 11. BIRTHPLACE (County & State, or foreign country): Michigan 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry True	14. MOTHER'S MAIDEN NAME: Mary Fellows
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI 16. SOCIAL SECURITY NO.: 396 36 0910 17. INFORMANT: Lillian L. True Address: (same as above)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL ISCHEMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS
DUE TO
(b): CEREBRAL VASCULAR DISEASE — 5 YEARS
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

3377

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SEVERE RHEUMATOID ARTHRITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from _____, 19 64, to 29 NOV, 19 67, that (I) ~~(we)~~ last saw the deceased alive on 9 NOV 19 67, and that death occurred at 445A M, from causes and on the date stated above.

22a. SIGNATURE: Frederick S Caldwell M.D.	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22b. DATE SIGNED: 11-19-67
22c. PHYSICIAN'S NAME (Type): FREDERICK S CALDWELL	22d. ADDRESS: ROCKVILLE MARYLAND			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 11/22/67	23c. NAME OF CEMETERY OR CREMATORY: Jon s Cem.	23d. LOCATION (City or Town) (County) (State): Jackson Miss.
24. FUNERAL DIRECTOR: Myron Peeler Funeral Home	ADDRESS: 1331 Rockville Pike Rockville, Md.	25a. REC'D BY REGISTRAR DATE: NOV 21 1967	25b. REGISTRAR'S SIGNATURE:

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm s may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health pr ar to burial, cremat on, ar removal, and in any event within 72 hours after death

15762

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15755

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 11200 Lockwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Louis — Middle: — Last: TURKOFF
4 DATE OF DEATH: Month: NOV. — Day: 28 — Year: 1967
5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4/12/04
9 AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed
10b KIND OF BUSINESS OR INDUSTRY: Dry Cleaning
11 BIRTHPLACE (State or foreign country): Russia
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13 FATHER'S NAME: Morris Turkoff
14. MOTHER'S MAIDEN NAME: Anna Zisselman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----------
16 SOCIAL SECURITY NO: 577-18-0690
17 INFORMANT: Irvin; Turkoff — Address: 11119 Stillwater Ave., Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Coronary Arterly Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural couses ☒ Accident ☐ Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Leap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. LEAP M.D. — Address (Street and No. or town or county): Rockville
22. DATE SIGNED: Nov. 28, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-30-67
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d LOCATION (City or Town) (County) (State): Falls Church, Va.

24 FUNERAL DIRECTOR — ADDRESS: Goldberg Funeral Home 4217 9th St., N.E.
25a REC'D BY REGISTRAR DATE: DEC 1 1967
25b REGISTRAR'S SIGNATURE: J. Charles Jagger

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15763

CERTIFICATE OF DEATH

15756

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Virginia — b. COUNTY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural) — c. LENGTH OF STAY IN 1b: 20 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval	d. STREET ADDRESS: 4241 South 35th Street — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print) First: Edward — Middle: A. — Last: WAGNER	4 DATE OF DEATH Month: November — Day: 22 — Year: 19 67
5 SEX: Male — 6 COLOR OR RACE: Cauc — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 2 Jan 1899 — 9 AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy (ret) — 10b KIND OF BUSINESS OR INDUSTRY: U. S. Navy (ret) — 11 BIRTHPLACE (County & State, or foreign country): Catasaqua, Penna. — 12 CITIZEN OF WHAT COUNTRY?: U.S.A.	
13. FATHER'S NAME: William WAGNER — 14. MOTHER'S MAIDEN NAME: Laurine BARTHOLMEW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes WW2 — 16 SOCIAL SECURITY NO.: 578-12-5722 — 17. INFORMANT: Mrs. Helen T. WAGNER — Address: 4241 South 35th Street Arlington, Virginia	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of the Stomach with massive
151 X
DUE TO: Metastasis to the Liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19 — 20d INJURY OCCURRED White at work ☐ Not While at work ☐ — 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) — 20f (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 2 November, 1967, to 22 November 1967, that (X) (we) last saw the deceased alive on 22 November 1967, and that death occurred at 1000A M, from causes and on the date stated above.

22a. SIGNATURE: Donald K. Roeder — M.D — ATTENDING PHYS. ☐ — MED DIRECTOR ☐ — STAFF PHYS. ☒ — 22b. DATE SIGNED: 23 Nov 1967

22c. PHYSICIAN'S NAME (Type): Donald K. ROEDER, LCDR MC USN — 22d ADDRESS: Naval Hospital, NNMC, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	27 Nov. 1967	Arlington National	Arlington Va.

24 FUNERAL DIRECTOR: EVERLY-WHEATLEY — ADDRESS: Alexandria, Virginia

25a. RECD BY REGISTRAR DATE: NOV 27 1967 — 25b. REGISTRAR'S SIGNATURE: Estelle Jordan

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2764 — 13757

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH — a. COUNTY: MONTGOMERY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGE
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): BETHESDA	c. LENGTH OF STAY IN 1b: 10 DAYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GREENBELT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN	d. STREET ADDRESS: 6003 CHERRYWOOD COURT — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First / Middle / Last	4. DATE OF DEATH Month / Day / Year
BERNARD / / WALDMAN	NOV 22 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
MALE	WHITE		9/21/08	59 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MANAGER	NORELCO SVS.	PENNA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Julius WALDMAN	FRANCES KIRSCHENBAUM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
NO		FLORENCE WALDMAN - WIFE — SAME

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	Min.
DUE TO (b)	acute myocardial infarction	16 hours
DUE TO (c)	arteriosclerotic heart disease	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): diabetes mellitus, obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Dec Nov 20 1962 to 12:35 pm Nov 22 19 67, that (I) ~~(we)~~ last saw the deceased alive on Nov 22 19 67, and that death occurred at 12:35 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22b. DATE SIGNED
Sidney J. MaLaver					Nov 22, 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Sidney J. Malaver, M.D.	8218 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/26/67	New Montefiore Cem.	Hollis, L.I. N.Y.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
D. Daugherty's Sons	3521-11th St. N.W. Washington, D.C.	NOV 27 1967	Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15765

CERTIFICATE OF DEATH

5758

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5306 Carvel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alan — Middle: Tower — Last: Waterman

4 DATE OF DEATH: Month: November — Day: 30 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 4 June 1892

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Scientist

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank A. Waterman

14 MOTHER'S MAIDEN NAME: Florence Tower

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — World War I

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Multiple Gastric Stress Ulcers — 2 Weeks
DUE TO
(c): Post-Operative bile Peritonitis — 3 Weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from November 14, 1967 to Nov. 30, 1967, that (X) (we) last saw the deceased alive on November 30, 1967, and that death occurred at 6:00 P.M. from causes and on the date stated above.

22a. SIGNATURE: Robert A. Ralph, M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 12/1/67

22c. PHYSICIAN'S NAME (Type): Robert A. Ralph, M. D.

22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: Dec.2,1967

23c NAME OF CEMETERY OR CREMATORY: Ft.Lincoln

23d LOCATION (City or Town) (County) (State): Bladensburg, P.G.'s Md.

24. FUNERAL DIRECTOR — ADDRESS: The S.H.Hines Co. 2901-14th.St.N.W. Wash.D.C.

25a. REC'D BY REGISTRAR — DATE: DEC 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

15759

15765

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Noe Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Lewisdale 15,1
d. STREET ADDRESS: RFD # 1, Monrovia
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha — Middle Ann — Last Watkins
4. DATE OF DEATH: Month November — Day 29 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 16, 1877
9. AGE (In years last birthday): 90 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Cedar Grove, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Burdette
14. MOTHER'S MAIDEN NAME: Laura V. Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Miss Ada Watkins, Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Advanced Arteriosclerotic Cardiovascular Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): No injury
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this physician)~~ attended the deceased from 1935, 19__, to November 29, 19 67, that (I) ~~(we)~~ last saw the deceased alive on November 27 19 67, and that death occurred at 10:37 A.M., from the causes and on the date stated above

22a. SIGNATURE: M. McKendree Boyer M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: November 30, 19 67
22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.
22d. ADDRESS: 9701 Church Street, Damascus, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bethesda Meth.
23d. LOCATION (City or Town) (County) (State): Browningsville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Molesworth, Damascus, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 25M 1/67

1

15767

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15760

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Rest Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5709 43rd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELISABETH Middle W. Last WEAVER

4. DATE OF DEATH: Month November Day 13 Year 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 21, 1900
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafateria Manager
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (County & State, or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Jesse H. Wilson
14. MOTHER'S MAIDEN NAME: Lizzie Woodward

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 276 30 1004
17. INFORMANT: Address: Frank L. Weaver Same as #2 (husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Diabetes — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): arterial Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1967, to Nov. 13, 1967 that (I) ~~(we)~~ last saw the deceased alive on Nov. 13 1967, and that death occurred at 9a M, from causes and on the date stated above.

22a. SIGNATURE: O B Little M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Nov. 13, 1967
22c. PHYSICIAN'S NAME (Type): A. B. LITTLE, M.D
22d. ADDRESS: 6911 5th St NW Wash DC 20012

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/16/67
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Oak Hill
23d. LOCATION (City or Town) (County) (State): Washington D. C.

24. FUNERAL DIRECTOR ADDRESS: Francis Gasch's Sons Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: NOV 17 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15768

13761

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH SAN & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: M.D. b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: 11227 Old Baltimore Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernard Middle: Landy Last: Wells

4. DATE OF DEATH: Month: Nov. Day: 13 Year: 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-31-94

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 7 Days 13
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESEARCH

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment Agricultural

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: John Wells

14. MOTHER'S MAIDEN NAME: Fannie Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT Address: Washington Sanitarium & Hospital CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of Urinary Bladder
1810
DUE TO (b): with metastasis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 10-13, 1967, to 11-13, 1967, that (I) (we) last saw the deceased alive on 11-12 1967, and that death occurred at 8 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/13/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/16/67

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Colmar Manor P.G. Md.

24. FUNERAL DIRECTOR ADDRESS: Francis Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: NOV 17 1967

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items 2, 3, 14, FilmGL02 7/2/68kc

CERTIFICATE OF DEATH

15762

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL - BURTONSVILLE
c. LENGTH OF STAY IN 1b: 3 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): LIPPARD NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland - Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6309 Landon Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Therese — Middle: GERTRUDE — Last: WESCHLER

4. DATE OF DEATH: Month: NOV. — Day: 8 — Year: 1967

5. SEX: FEM.

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG. 21, 1887

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLEMENT KROGMANN

14. MOTHER'S MAIDEN NAME: Mary M. LOCHBOEHLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): - - -
(If yes give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: MRS. ANNA L. RUPPERT — Address: 5420 CONN. AVE. N.W. WASH. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma from — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Breast - undetermined to bone
DUE TO (c): and Lungs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute + Chronic Hemorrhagic Cystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/19, 1967, to 11/8, 1967, that (I) (we) last saw the deceased alive on 10/27, 1967, and that death occurred at 2025 M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Smith, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Joseph E. Smith, Jr. M.D

22d. ADDRESS: Burtonsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-11-1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Oliver, Cemetert

23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: NOV 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15770

CERTIFICATE OF DEATH

15763

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9525 Linden Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: DAISY — Middle: I. — Last: WHITON

4 DATE OF DEATH: Month: Nov. — Day: 9, — Year: 1967

5 SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		8/15/81	86 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Atlanta, Ga.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT: 4741 ont_mery Ave. Bet[illegible]
No	220-4[illegible]-9180[illegible]	[illegible]

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	DEHYDRATION & ACIDOSIS	3 DAYS
DUE TO (b)	LOWER BOWEL OBSTRUCTION	1 WEEK
DUE TO (c)	CARCINOMA (RECTAL)	1 YEAR

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): GENERALIZED ARTERIOSCLEROSIS

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from FEBRUARY, 1967, to NOV. 10, 1967, that (I) (we) last saw the deceased alive on Nov. 9, 1967, and that death occurred at 7:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Joseph J. Connor, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 11/9/67

22c. PHYSICIAN'S NAME (Type): Jose[illegible] J. Connor — 22d ADDRESS: 9422 Old Georgetown Rd., Bethe[illegible], Md

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	11/14/67	Arlington National	Arlington, Va.

24 FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike, Rockville, Md.

25a REC'D BY REGISTRAR — DATE: NOV 14 1967 — 25b REG'STRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15771 — 15764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1mo 22dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3333 University Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle T — Last WILLETT

4. DATE OF DEATH: Month Nov — Day 11 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-3-1900

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William W. Illett

14. MOTHER'S MAIDEN NAME: Frances Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-44-9339

17. INFORMANT: Wife — Address: Helene Willett — Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypoprotenimia
DUE TO (b): Lung Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Laennec's Cirrhosis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1967 to Nov 11, 1967, that (I) (we) last saw the deceased alive on Nov 7 1967, and that death occurred at 12:05 PM, from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-11-67

22c. PHYSICIAN'S NAME (Type): Robert T. Thibadeau

22d. ADDRESS: 11,000 Old Geroegetown Road Rockville Maryland 20852

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-15-67

23c. NAME OF CEMETERY OR CREMATORY: Baltimore Natl Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: NOV 14 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4) 20M 1/65

4 1

MARYLAND STATE DEPARTMENT OF HEALTH

15772 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15765

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE: WASH. D.C. — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK — c. LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASH. D.C.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM & HOSP.	d. STREET ADDRESS: 1436 OGLETHORPE ST NW. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRIETT — Middle B (~~TATE~~) — Last WILLIAMS	4. DATE OF DEATH: Month Nov. — Day 14 — Year 1967						
5. SEX: F	6. COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 1-15-02	9. AGE (In years last birthday): 65 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF.	10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: WM. BALDTMANN	14. MOTHER'S MAIDEN NAME: Julia M. Elliott						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16. SOCIAL SECURITY NO 577-09-8559	17. INFORMANT (HUSBAND) WARREN-WILLIAMS — Address SAME					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Congestive heart failure due to

DUE TO (b): Pneumonia, aspiration

DUE TO (c): Cerebral arteriosclerosis

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 week (b) Indefinite (c) Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-8, 1967, to 11-14, 1967, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 6:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Chas H Wolohon, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Chas H Wolohon — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: 11-17-67	23c. NAME OF CEMETERY OR CREMATORY: WASHINGTON NAT. CEM.	23d. LOCATION (City or Town) (County) (State): SUITLAND MARYLAND
24. FUNERAL DIRECTOR: Joseph Gawler's Sons	ADDRESS: 5808 Wisconsin Ave.	25a. REC'D BY REGISTRAR DATE NOV 20 1967	25b. REGISTRAR'S SIGNATURE: Minnie George

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15773 — 13766

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 43 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 2806 Radius Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Francis	I.	Wood	11	1	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W		7-24-14	53 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Postal Supervisor	U.S. Post Office	Washington, D. C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis I. Wood	Catherine O'Neil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
Yes — WW II	578-40-3723	John Wood	7403 Buchanan Street Hyattsville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cancer of esophagus & metastases — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from March, 1967, to 11-1-67, 19__, that (I) ~~(we)~~ last saw the deceased alive on 11-1 1967, and that death occurred at 6:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Morris Perry — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11-7-67
22c. PHYSICIAN'S NAME (Type): Morris ~~Rex~~ Perry — 22d. ADDRESS: 11602 Georgia Avenue, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 6, 1967	Arlington National Cem.	Arlington, Virginia

24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE NOV 3 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Items 18-21 Film #395
11-30-67 mt

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15767

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 75 East Wayne Ave., #505
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELDA Middle RUTH Last WOOD

4. DATE OF DEATH: Month November Day 15 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-28-29
9. AGE (In years last birthday): 38 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Counsler
10b. KIND OF BUSINESS OR INDUSTRY: Suburban Personel
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: A.J. Norton
14. MOTHER'S MAIDEN NAME: Ruth Sparks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT Address: Mr. James F. Wood, Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiorespiratory Failure due
7/0 +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): to Barbiturate Intoxication
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Deceased took overdose of Nembutal Capsules
20c. TIME OF INJURY Month, Day, Year: Hour a.m. ? p.m. 11-15-67 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Motel
20f. (City or town) Silver Spring (County) Montgomery (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Read M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. READ M.D.
Address (Street or R.F.D., Town, County): Wheaton, Md.
22. DATE SIGNED: 11/15/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11/18/67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City or Town) (County) (State): Prince Georges County Md.

24. FUNERAL DIRECTOR: Glen Carter C. Glen Carter
ADDRESS: Silver Spring
Warner E. Pumphrey Inc. 8434 Georgia Ave.

25a. RECD BY REGISTRAR DATE: NOV 22 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15775 — 15758

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: MONTGOMERY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
   c. LENGTH OF STAY IN 1b: 1-Month.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Silver Spring~~ Wheaton
   d. STREET ADDRESS: 2374 GLENMONT CIRCLE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CALVIN — Middle: Eugene — Last: WRIGHT

4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 5-1-14

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLUMBER

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (County & State, or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Burrell W. Wright

14. MOTHER'S MAIDEN NAME: Una Lea Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO: yes

17. INFORMANT: Edith Mae Wright — Address: 2374 Glenmont Circle Wheaton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE [redacted]
DUE TO: PULMONARY INFARCTS. CHRONIC ATRIAL FIBRILLATION.
410 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): RHEUMATIC HEART DISEASE, MITRAL + AORTIC STENOSIS — INTERVAL BETWEEN ONSET AND DEATH: 36 YEARS.
DUE TO
(c): ~~STREPTOCOCCAL INFECTION~~ — INTERVAL BETWEEN ONSET AND DEATH: AS ABOVE.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): RENAL INSUFICIENCY, PULMONARY INSUFICIENCY, PULMONARY EMPHYSEMA & FIBROSIS.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August, 1967, to November 14 1967, that (I) (we) last saw the deceased alive on November 14 1967, and that death occurred at 11 P M, from causes and on the date stated above.

22a. SIGNATURE: Hugo G. Graziani — M.D. — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 11/14/67

22c. PHYSICIAN'S NAME (Type): HUGO G. GRAZIANI, MD

22d. ADDRESS: 10101 GEORGIA AVE, SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR: John B. Thomas Thomas 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: NOV 17 1967

25b. REGISTRAR'S SIGNATURE: Stanley Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5778 15769

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home 901 Argyle Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 2213 Calvert St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mrs — Middle: Lula — Last: Irwin Yilek

4. DATE OF DEATH: Month: Nov. — Day: 24 — Year: 19 67

5. SEX: female — 6. COLOR OR RACE: white — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 11/9/94 — 9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Mississirri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Harris Irwin
14. MOTHER'S MAIDEN NAME: Anna Laura Key

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-10-4859L
17. INFORMANT: John F. Yilek-2118 Beechwood Rd. West Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Astrocytoma of Brain
1730
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 8-9 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/27, 1967 to 11/24, 19 67 that (I) (we) last saw the deceased alive on 11/24 19 67, and that death occurred at 10:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William Brainin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/24/67
22c. PHYSICIAN'S NAME (Type): WM BRAININ
22d. ADDRESS: 6124 Central Ave Capitol Heights Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 11/27/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: NOV 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 '67
20M 5-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15777 — 15770

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Virginia — b. COUNTY: Fairfax
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b: 27 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): The Clinical Center, Bethesda, Maryland	d. STREET ADDRESS: 8115 Springfield Village Drive — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: Cyrus — Last: Young	4. DATE OF DEATH: Month: November — Day: 16 — Year: 1967					
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 3 October 1923	9. AGE (In years last birthday): 44 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supply Specialist	10b. KIND OF BUSINESS OR INDUSTRY: Navy	11. BIRTHPLACE (County & State, or foreign country): Rhode Island	12. CITIZEN OF WHAT COUNTRY?: USA			
13. FATHER'S NAME: George Young	14. MOTHER'S MAIDEN NAME: Alvina Varin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1943-1946	16. SOCIAL SECURITY NO.: 039-05-7464	17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Encephalapathy — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
(b): Carcinoma of Pancreas with metastasis to Liver — 4 Months
DUE TO
(c):

157 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (X) (this hospital) attended the deceased from Oct. 20, 1967, to Nov. 16, 1967, that (X) (we) last saw the deceased alive on Nov. 16 1967, and that death occurred at 9:00 PM from causes and on the date stated above.

22a. SIGNATURE: John W. Keyes Jr.	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED: 17 Nov. 1967		
22c. PHYSICIAN'S NAME (Type): John W. Keyes, Jr., MD.	22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Nov. 20, 1967	23c. NAME OF CEMETERY OR CREMATORY: Young's Family	23d. LOCATION (City or Town) (County) (State): Johnston, Rhode Island	
24. FUNERAL DIRECTOR: Arnold F. Burner	ADDRESS: Cunningham Funeral Home Cameron & Alfred Alex., Va.	25a. REC'D BY REGISTRAR DATE NOV 21 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17412

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY: C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 6709 - 16th St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIOLET Middle H. Last ZENTZ
4. DATE OF DEATH: Month Nov. Day 29, Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Apr. 9, 1893
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Parochial Care Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: August Beushauser
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Rose Lambs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 394-05-9208
17. INFORMANT: Son, Rodney G. Zentz — ADDRESS: 2670 Univ.Blvd.,W. Wheaton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
6000
DUE TO (b): with Cardiomegaly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Acute Pyelonephritis with Uremia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Belden R. Reap, M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Wheaton, Md.
22. DATE SIGNED: 12-1-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-3-67
23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore County, Md.

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Grange

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67